Introductory Training for First Steps Providers

Basic Overview of First Steps
Track III

Form 5: Provider Agreement

In both Track I and II we have referred to the Provider Agreement. Having an approved Provider Agreement is essential. If you, as an independent provider, or your agency do not receive an approved provider agreement, signed by the DPH's Director, any services you provide will not be reimbursed.

This Track is intended to help you accurately complete each form. Submitting incomplete forms will delay processing and prevent you from initiating services.

Form 5: Provider Agreement, pg. 1

Rev. 3/04.

Leave blank → **Provider Number: FS-_____**

COMMONWEATH OF KENTUCKY
Cabinet for Health and Family Services
DIVISION ADULT & CHILD HEALTH, DEPARTMENT FOR PUBLIC HEALTH
FIRST STEPS

Leave blank ↘

PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the _____**day** of _____ **200** ____ by and between the Commonwealth of Kentucky, Division Adult & Child Health, Department for Public Health, Kentucky Early Intervention, 275 East Main, Frankfort, Kentucky 40621, hereinafter referred to as ACH and

_____
(Name of Provider)

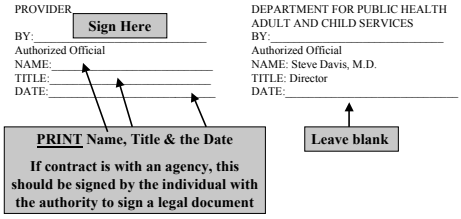
_____
(Address, City, State, Zip of Provider)

hereinafter referred to as the Provider.

Fill in your Name or the Name of your Business & Address

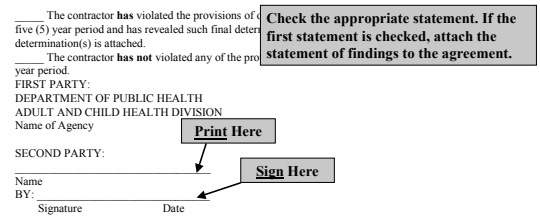
Form 5: Provider Agreement, pg. 3

Read the full text of the Provider Agreement pages 1 and 2 sign page 3 as shown below:



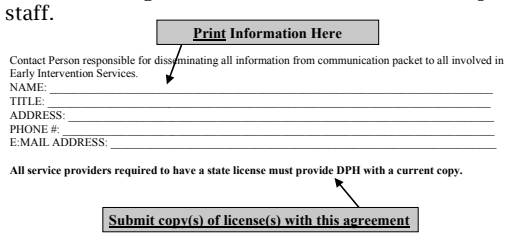
Form 5: Provider Agreement, pg. 3

Read carefully the full text of the Provider Agreement page 3 regarding Violation of Tax & Employment Laws.



Form 5: Provider Agreement, pg. 3

The contact person you designate will be responsible for maintaining communication with the First Steps staff.



Form 6: CBIS Provider Enrollment

The Provider Enrollment form provides for a standardized method to:

⌘Collect demographic information about your business entity
⌘Identify employees who will provide services to KEIS recipients
⌘Report changes to any demographic information

Before completing this form, give careful consideration to your business structure.

⌘What will you name your business?
⌘Will you operate using your SS#?
⌘Where is your business located?

Form 6: CBIS Provider Enrollment

13 service providers can be listed on this page. If more than 13, fill in appropriate number of pages

As a new provider, mark this box

Leave blank

Page 1 of ___ FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

☐ New ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps S

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

SECTION 1: BILLING INFORMATION

1. Business Name			2. Federal Tax ID/Soc. Sec. #
3. Street Address Line 1			
4. Street Address Line 2			
5. City	6. State	7. Zip	8. First Steps Contract Administrator: Name: Email:
9. Telephone		10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship C. Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit			13. District(s) Served:

Form 6: CBIS Provider Enrollment

List your legal business name & address

Page 1 of _1_ FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

☒ New ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps Services

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

SECTION 1: BILLING INFORMATION

1. Business Name			2. Federal Tax ID/Soc. Sec. #
3. Street Address Line 1			
4. Street Address Line 2			
5. City	6. State	7. Zip	8. First Steps Contract Administrator: Name: Email:
9. Telephone		10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship C. Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit			13. District(s) Served:

Form 6: CBIS Provider Enrollment

List your Federal Tax ID or Social Security number

Page 1 of 1

FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

☒ New ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps Services

Indicate your tax status

SECTION 1: BILLING INFORMATION

1. Business Name ABC Therapy	2. Federal Tax ID/Soc. Sec. #
3. Street Address Line 1 123 Main Street	
4. Street Address Line 2 Suite 101	
5. City Somerset / 6. State KY / 7. Zip 42500	8. First Steps Contract Administrator: Name: Email:
9. Telephone / 10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship C. Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	13. District(s) Served:

Form 6: CBIS Provider Enrollment

Indicate the district(s) where you practice.

Page 1 of 1

FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

☒ New ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps Services

SECTION 1: BILLING INFORMATION

1. Business Name ABC Therapy	2. Federal Tax ID/Soc. Sec. # 61-999999
3. Street Address Line 1 123 Main Street	
4. Street Address Line 2 Suite 101	
5. City Somerset / 6. State KY / 7. Zip 42500	8. First Steps Contract Administrator: Name: Email:
9. Telephone / 10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship (C) Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	13. District(s) Served:

Form 6: CBIS Provider Enrollment

List the name, phone #, fax # and email address of the designated contact person. This person will be responsible for informing Provider Relations about changes in the provider's information

Page 1 of 1

FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

☒ New ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps Services

SECTION 1: BILLING INFORMATION

1. Business Name ABC Therapy	2. Federal Tax ID/Soc. Sec. # 61-999999
3. Street Address Line 1 123 Main Street	
4. Street Address Line 2 Suite 101	
5. City Somerset / 6. State KY / 7. Zip 42500	8. First Steps Contract Administrator: Name: Email:
9. Telephone / 10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship (C) Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	13. District(s) Served: Lake Cumberland

Form 6: CBIS Provider Enrollment

Page 1 of _1_ FORM 6 Revised 7-04

FIRST STEPS CBIS PROVIDER ENROLLMENT FORM PROVIDER ID #_____

FS OFFICE USE ONLY
Program Consultant(s):_____
DATE: _____

☒ N e w ☐ Contract Renewal

☐ Addendum *Indicate (A) Add, (LA) Leaving Agency or (DFS) Discontinuing First Steps Services

SECTION 1: BILLING INFORMATION

1. Business Name ABC Therapy	2. Federal Tax ID/Soc. Sec. # 61-999999
3. Street Address Line 1 123 Main Street	
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5. City Somerset / 6. State KY / 7. Zip 42500	8. First Steps Contract Administrator: Name: Email:
9. Telephone / 10. Fax	11. Billing Contact Person (if different from Administrator) Name: Email:
12. Tax Status: (Circle One): A. Individual B. Sole Proprietorship (C) Partnership D. Estate/Trust E. Corporation F. Public Service Corporation (PSC) G. Government/Non-Profit	13. District(s) Served: Lake Cumberland

Form 6: CBIS Provider Enrollment

If you have other additional funding sources to provide KEIS services, please list the source and amount. This will not affect reimbursement for services provided through First Steps.

SECTION 2: SOURCES OF ALTERNATE FUNDING	
SOURCE	AMOUNT

Please indicate any additional sources you currently have to provide services to KEIS eligible children. NOTE: This information will not be used in any way to deny payment of KEIS eligible services. This information is simply to provide KEIS with an understanding of how much funding is adequate to meet the early intervention needs of children in Kentucky.

Form 6: CBIS Provider Enrollment

As a New Provider, Leave blank

Enter the name of each person who will provide First Steps services under this agreement Do not use nicknames.

SECTION 3: SERVICE PROVIDER(S) AND DISCIPLINE(S)

Enter "SE" Beside Name to Identify Active or Retired State Employee

*ALA DFS	SERVICE PROVIDERS	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE NUMBER	COUNTY(IES) TO BE SERVED	FS OFFICE USE ONLY TRAINING

Form 6: CBIS Provider Enrollment

Enter the Social Security #, Discipline Code(s) and License # for each person who will provide First Steps services under this agreement.

SECTION 3: SERVICE PROVIDER(S) AND DISCIPLINE(S)

Enter "SE" Beside Name to Identify Active or Retired State Employee						FS OFFICE USE ONLY
*A/LA DFS	SERVICE PROVIDERS	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE NUMBER	COUNTY(IES) TO BE SERVED	TRAINING
	Sue Smith					
	John Stevens					
	Jane Doe					

Form 6: CBIS Provider Enrollment

List County(ies) to be served **Leave blank**

SECTION 3: SERVICE PROVIDER(S) AND DISCIPLINE(S)

Enter "SE" Beside Name to Identify Active or Retired State Employee						FS OFFICE USE ONLY
*A/LA DFS	SERVICE PROVIDERS	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE NUMBER	COUNTY(IES) TO BE SERVED	TRAINING
	Sue Smith	111-11-1111	11	####		
	John Stevens	222-22-2222	11	####		
	Jane Doe	333-33-3333	12	####		

* LIST ADDITIONAL STAFF ON 8-ADD

Form 6: CBIS Provider Enrollment

PAGE _____ OF _____

Date: _____ FORM 6-A Rev. 7-04

FIRST STEPS CBIS PROVIDER ENROLLENT FORM

Provider Name: _____ Provider CBIS ID: _____

SECTION 3: SERVICE PROVIERD(S) AND DISCIPLINE(S) (Continuation

Enter "SE" Beside Name to Identify Active or Retired State Employee						FS OFFICE USE ONLY
*A/LA DFS	SERVICE PROVIDERS	SOCIAL SECURITY #	DISCIPLINE CODE(S)	LICENSE NUMBER	COUNTY(IES) TO BE SERVED	TRAINING

Continue listing staff on this page, if needed

Form 6: CBIS Provider Enrollment

Provider Authorized signature:
I certify, under penalty of law, that the information given in this Enrollment form is correct and completed to the best of my knowledge. I am aware that, should investigation at any time show any falsification, a consideration for suspension from the First Steps Program and/or prosecution for fraud may occur. I hereby authorize the Cabinet to make all necessary verifications concerning the information provided, and authorize licensing boards or other organizations to provide all information that may be sought in connection with the application to participate in the First Steps Program.

Signature: _____
Name: _____
Title: _____

The person who signs Form 6 should be the same person who signed Form 5 as the <u>authorized official</u>.

<u>Print</u> name & title.

Form 8: Electronic Media Addendum

This form outlines the responsibilities of a contracting agency who may submit claims via electronic media, e.g., fax or email.

Even though you may not plan to routinely submit claims electronically, having this form on file will allow you to do so without experiencing delays in processing.

Form 8: Electronic Media Addendum

This <u>required</u> form enables electronic bill submission to CBIS.

Form 8-FY2002
Rev. 8/01

Leave blank

Cabinet for Health and Family Services

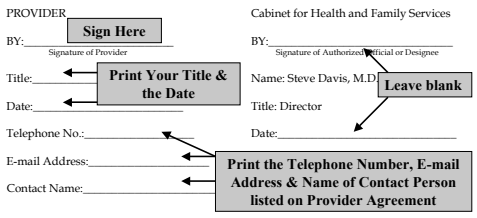
<u>First Steps Provider Agreement Electronic Media Addendum</u>

This addendum to the Provider Agreement is made and entered into as of the _____day of _____, 20_____, by and between the Commonwealth of Kentucky, Cabinet for Health and Family Services, hereinafter referred to as the Cabinet, and _____ hereinafter referred to as the Provider.

Enter Name & Address of Provider

Form 8: Electronic Media Addendum

Read the form carefully before signing. **An original signature is required** - do not FAX or email Form 8.



Form 6: CBIS Provider Enrollment

- Mail the signed CBIS Provider Enrollment form with the Provider Agreement to:
  Department for Public Health
  ACHI / Early Childhood Development Branch
  275 East Main Street, HS2W-C
  Frankfort KY 40621
- **Original signatures are required.** FAX and email documents are not accepted.
- Attach any required documents: copy(s) of professional license(s), statement of findings if you check the statement indicating a violation of tax & employment statutes.
- **Any changes to the Provider Enrollment must be submitted on Form 6ADD, the addendum form, and sent to DPH within 10 (ten) days. All communication must include your CBIS-assigned provider number.**
- **Don't forget to submit a new W-9 (an IRS form) whenever you change your name. It ensures that the correct name is linked to your tax I.D. number. This will not affect your CBIS provider number.**

ASSIGNMENT

- ❑ Print and complete mandatory Track III Post Test.
- ❑ You must follow all instructions carefully. Failure to properly follow instructions may result in your contract being denied.